

<b>THIRD PARTY COLLECTION PROGRAM - RECORD OF OTHER HEALTH INSURANCE</b> <i>(Read Privacy Act Statement before completing this form.)</i>										<i>Form Approved</i> <b>OMB No. 0704-0323</b> <i>Expires Jul 31, 2003</i>	
The public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0323), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.											
<b>PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.</b>											
<div style="text-align: center;"><b>PRIVACY ACT STATEMENT</b></div> <p><b>AUTHORITY:</b> Title 10 USC, Sec. 1095; EO 9397.  <b>PRINCIPAL PURPOSE(S):</b> Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.  <b>ROUTINE USE(S):</b> The information on this form will be released to your insurance company.  <b>DISCLOSURE:</b> Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.</p>											
1. PATIENT NAME <i>(Last, First, Middle Initial)</i>			2. SSN			3. DATE OF BIRTH <i>(YYYYMMDD)</i>			4. MARITAL STATUS <i>(X)</i> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED/WIDOWED		
5a. STREET ADDRESS <i>(Include apartment number)</i>				b. CITY		c. STATE		d. ZIP CODE		6. HOME TELEPHONE NO. (      )	
7. SPONSOR'S BRANCH OF SERVICE			8. SPONSOR FAMILY MEMBER PREFIX/SSN			9a. SPOUSE NAME <i>(Last, First, Middle Initial)</i>					
10a. PATIENT'S EMPLOYER NAME				b. TELEPHONE NUMBER (      )		b. SPOUSE'S EMPLOYER <i>(Name, Address and Telephone No.)</i>					
c. EMPLOYER ADDRESS <i>(Include ZIP Code)</i>											
11. IS PATIENT'S CONDITION/APPOINTMENT RELATED TO AN ACCIDENT <i>(X one)</i>				<input type="checkbox"/> YES <input type="checkbox"/> NO		a. DATE OF INJURY/ACCIDENT <i>(YYYYMMDD)</i>			b. CITY AND STATE WHERE ACCIDENT OCCURRED		
c. TYPE OF ACCIDENT <i>(X)</i>		<input type="checkbox"/> AUTO		<input type="checkbox"/> BOAT		<input type="checkbox"/> HOME		<input type="checkbox"/> AIRPLANE		<input type="checkbox"/> WORKERS' COMPENSATION	
		<input type="checkbox"/> SLIP & FALL		<input type="checkbox"/> OTHER							
d. BRIEFLY DESCRIBE HOW INJURY/ACCIDENT OCCURRED											
e. INSURANCE COMPANY NAME				f. POLICY NUMBER		g. COMPANY ADDRESS <i>(Include ZIP Code)</i>					
h. TELEPHONE NUMBER (      )			i. NAME OF POLICY HOLDER/INSURED						j. CLAIM NUMBER		
12. DO YOU HAVE MEDICARE/MEDICAID <i>(X one)</i>											
a. MEDICARE PART A NUMBER		b. MEDICARE PART B NUMBER				c. MEDICAID NUMBER		d. ISSUING STATE			
13. ARE YOU COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY? <i>(Other than Medicare, Medicaid, TRICARE or TRICARE/CHAMPUS Supplement)</i>										<input type="checkbox"/> YES <input type="checkbox"/> NO	
14.a. PRIMARY MEDICAL INSURANCE COMPANY NAME						15.a. SECONDARY MEDICAL INSURANCE COMPANY NAME					
b. ADDRESS <i>(Include ZIP code)</i>						b. ADDRESS <i>(Include ZIP code)</i>					
c. TELEPHONE NUMBER (      )		d. IDENTIFICATION NUMBER/GROUP NUMBER				c. TELEPHONE NUMBER (      )		d. IDENTIFICATION NUMBER/GROUP NUMBER			
e. POLICY HOLDER'S NAME <i>(Last, First, Middle Initial)</i>						e. POLICY HOLDER'S NAME <i>(Last, First, Middle Initial)</i>					
f. SSN			g. DATE OF BIRTH <i>(YYYYMMDD)</i>			f. SSN			g. DATE OF BIRTH <i>(YYYYMMDD)</i>		
h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.						h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.					
i. EFFECTIVE DATE OF POLICY <i>(YYYYMMDD)</i>						i. EFFECTIVE DATE OF POLICY <i>(YYYYMMDD)</i>					
16. FAMILY MEMBERS COVERED BY ABOVE POLICIES <i>(Use additional pages if necessary)</i>											
a. NAME <i>(Last, First, Middle Initial)</i>			b. SSN		c. DATE OF BIRTH <i>(YYYYMMDD)</i>		a. NAME <i>(Last, First, Middle Initial)</i>			b. SSN	
										c. DATE OF BIRTH <i>(YYYYMMDD)</i>	
17. CERTIFICATION. I certify that the above information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by 18 USC 1001, which provides for a maximum fine of \$10,000 or imprisonment for five years, or both. For non-DoD beneficiaries, the below signature authorizes and requests that the proceeds of any and all benefits be paid directly to the Military Treatment Facility (MTF) for health care services provided me and/or my minor dependents. This signature authorizes Medical Service Account (MSA) patients' release of medical information (medical records) for claims.											
a. SIGNATURE										b. DATE <i>(YYYYMMDD)</i>	